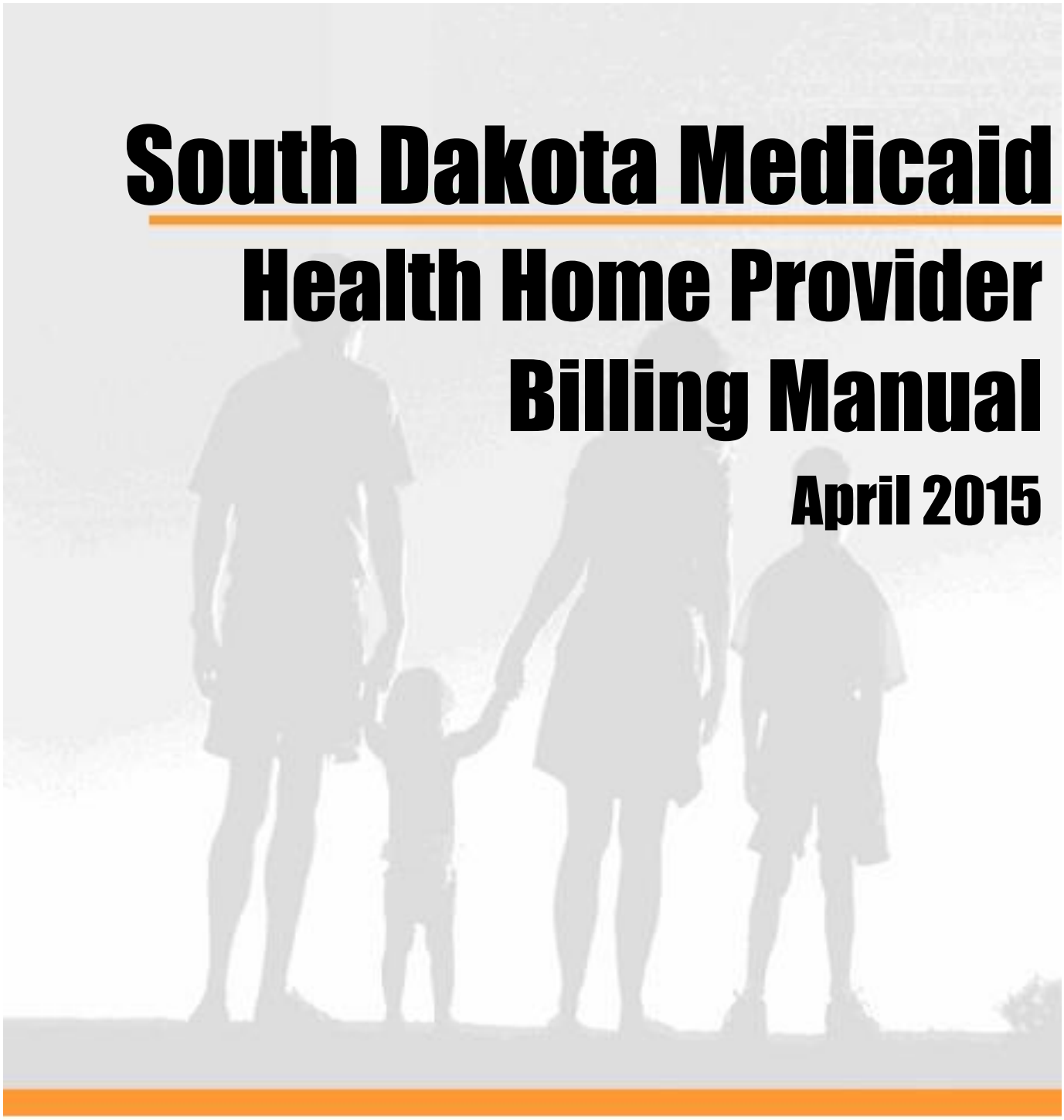
South Dakota Medicaid

Health Home Provider Billing Manual

April 2015



DSS

Strong Families - South Dakota's Foundation and Our Future

Important Contact Information

<table>
<tr><td colspan="2">Telephone Service Unit for Claim Inquiries
In State Providers: 1-800-452-7691
Out of State Providers: (605) 945-5006</td></tr>
<tr><td colspan="2">Provider Response for Enrollment and Update Information
1-866-718-0084
Provider Enrollment Fax: (605) 773-8520
Email: SDMEDXGeneral@state.sd.us</td></tr>
<tr><td colspan="2">Prior Authorizations
Pharmacy Prior Authorizations: 1-866-705-5391
Medical and Psychiatric Prior Authorizations: (605) 773-3495</td></tr>
<tr><td>Dental Claim and Eligibility Inquiries
1-800-627-3961</td><td>Recipient Premium Assistance
1-888-828-0059</td></tr>
<tr><td>Managed Care and Health Home Updates
(605) 773-3495</td><td>SD Medicaid for Recipients
1-800-597-1603</td></tr>
<tr><td colspan="2">Medicare
1-800-633-4227</td></tr>
<tr><td colspan="2">Division of Medical Services
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291
Division of Medical Services Fax: (605) 773-5246</td></tr>
<tr><td colspan="2">Medicaid Fraud</td></tr>
<tr><td>Welfare Fraud Hotline: 1-800-765-7867

File a Complaint Online:
http://atg.sd.gov/TheOffice/Divisions/MedicaidFraudControlUnit.aspx</td><td>OFFICE OF ATTORNEY GENERAL
MEDICAID FRAUD CONTROL UNIT
Assistant Attorney General Paul Cremer
1302 E Hwy 14, Suite 4
Pierre, South Dakota 57501-8504
PHONE: 605-773-4102 FAX: 605-773-6279
EMAIL:
ATGMedicaidFraudHelp@state.sd.us</td></tr>
<tr><td colspan="2">Join South Dakota Medicaid’s listserv to receive important updates and guidance from the Division of Medical Services:
http://www.dss.sd.gov/medicaid/contact/ListServ.aspx</td></tr>
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Preface

The purpose of this Manual is to provide Medicaid policy and guidance to providers participating in the South Dakota Medicaid Health Home Program. It is designed to provide instructions to complete and submit forms and documents.

Policy statements and requirements governing the Health Home Program are included. The Manual is formatted to incorporate changes as additional information and periodic clarifications are necessary.

Before rendering service to a client, providers are responsible for familiarizing themselves with all Medicaid procedures and regulations, currently in effect and those issued going forward, for the Health Home Program. The Health Home Program is an optional service within the South Dakota Medicaid State Plan.

Be advised that the Department of Social Services publishes a quarterly newsletter, the Division of Medical Services' Provider Newsletter which contains information on Medicaid programs, policy and billing. It is sent to all active enrolled providers. New providers should be familiar with current and past issues of the Division of Medical Services' Provider Newsletter to be current on policy and procedures.

Note: Although every effort has been made to keep this policy manual updated, the information provided is subject to change. Medicaid program policy concerning this Health Home initiative may be found at the Department of Social Services website listed below.

http://dss.sd.gov/healthhome/providers.aspx

Statutory Authority and Overview of Health Homes

Patient Protection and Affordable Care Act

The goal of Health Homes is to improve care and health outcomes, lower Medicaid costs and reduce preventable hospitalizations, emergency room visits and unnecessary care for Medicaid recipients.

Health Homes is an option afforded to States under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703, allows states under the state plan option or through a waiver, the authority to implement Health Homes effective January 1, 2011. The purpose of Health Homes is to provide the opportunity to States to address and receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for

persons with chronic conditions. States approved to implement Health Homes are eligible for 90 percent Federal match for health home services for the first eight (8) fiscal quarters that a health home state plan amendment is in effect. The Health Homes State Plan Amendment can be found at http://dss.sd.gov/docs/medicaid/medicalservices/3_ServicesGeneralProvisions/3.1/Attachment%203.1-H.pdf

State Medicaid Director Letter: Health Homes for Members with Chronic Conditions

State Medicaid Director Letter (SMDL), #10-024, Health Homes for Members with Chronic Conditions, provides preliminary guidance to States on the implementation of Section 2703 of the Affordable Care Act, entitled "State Option to Provide Health Homes for Members with Chronic Conditions." A link to the State Medicaid Director's letter has been provided below for additional information:
http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

The Health Home Program was one of eleven (11) recommendations of the Medicaid Solutions Workgroup appointed by Governor Dennis Daugaard in 2011. The Medicaid Solutions Workgroup was charged with identifying ways to reduce costs and improve the quality and efficiency of care within the South Dakota Medicaid program. The complete Final Report of the Medicaid Solutions Workgroup can be found at http://dss.sd.gov/docs/news/reports/11-23-11MedicaidSolutionsReport.pdf

To assist in implementing this recommendation, the Department of Social Services appointed a Health Home Planning Workgroup made up of stakeholders. The Workgroup was used to make decisions about what the Health Home program would look like in South Dakota. DSS continues to work with an Implementation Workgroup to help develop policies as needed. Outputs from this group can be found on http://dss.sd.gov/healthhome/workgroup.aspx

On November 21, 2013, the US Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) approved South Dakota's Health Home State Plan Amendment (SPA). The SPA was effective July 1, 2013

Introduction

This manual is one of a series published for use by medical services providers enrolled in South Dakota Medicaid. It is designed to be readily updated by replacement or addition of individual pages as necessary. It is designed to be used as a guide in preparing claims, and is not intended to address all South Dakota Medicaid rules and regulations. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing South Dakota Medicaid in Article § 67:16.

Problems or questions regarding South Dakota Medicaid rules and policies as well as claims, covered services, and eligibility verification should be directed to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291
Phone: (605) 773-3495

Problems or questions concerning recipient eligibility requirements can be addressed by local field offices of the Department of Social Services in your area or can be directed to:

Department of Social Services
Division of Economic Assistance
700 Governors Drive
Pierre, SD 57501-2291
Phone: (605) 773-4678

Medicare is a separately administered federal program and questions concerning Medicare cannot be answered by South Dakota Medicaid Program personnel.

General Information

The purpose of the Medicaid Program (Title XIX) is to assure the availability of quality medical care to low-income individuals and families through payments for a specified range of services. The Medicaid program was implemented in South Dakota in 1967.

Funding and control of Medicaid are shared by federal and state governments under Title XIX of the Social Security Act; regulations are written to comply with the actions of Congress and the State Legislature.

A brief description of general information about the Medicaid program is provided in this manual. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing Medicaid in Article § 67:16.

Provider Responsibility

Provider Identification Number

A provider of health care services must have a ten (10) digit National Provider Identification (NPI) number. This number should be included on all correspondence with the Department of Social Services.

Enrollment

Providers, who render one or more services covered under the Medicaid Program, and who wish to participate in the Medicaid Program, must become an enrolled provider. The provider must complete an online enrollment application, comply with the terms of participation, as identified in the agreement and requirements, stated in Administrative Rules of South Dakota ARSD § 67:16 which govern the Medicaid Program, and sign a Provider Agreement. Failure to comply with these requirements may result in monetary recovery, or civil or criminal action.

An individual (i.e. consultant, staff, etc.) who does not have a provider agreement, but who furnishes a covered service to a recipient under your provider agreement and receives payment or benefits indirectly from the Department of Social Services, is also subject to the rules, regulations and requirements of the South Dakota Medicaid Program.

Participating providers agree to accept Medicaid payment as payment in full for covered services. The provider must NOT bill any of the remaining balance to the recipient, their family, friends or political subdivisions.

Enrollment Record Maintenance

It is the provider's responsibility to maintain their enrollment record to accurately reflect their business practices and status as a health care provider. This includes, but is not limited to, addresses, licensure (entity & practitioner level), payment details, ownership and controlling interests, billing agent/clearinghouse relationships, exclusionary status, and individual participation (if individual leaves practice, must end date on enrollment record).

Licensing Change

A participating provider must update their SD MEDX enrollment record to show the provider's licensing or certification status within ten days after the provider receives notification of a change in status. This includes updates to license expiration. If a provider's licensure ends due to choice, death, disciplinary action, or any other reason, there must also be an email notification to SDMEDXGeneral@state.sd.us outlining the reason for the provider's closure.

Termination of Agreement

When a provider agreement has been terminated, the Department of Social Services will not pay for services provided after the termination date. Pursuant to ARSD § 67:16:33:04, a provider agreement may be terminated for any of the following reasons:

- The agreement expires
- The provider fails to comply with conditions of the signed provider agreement or conditions of participation
- The ownership, assets, or control of the provider's entity are sold or transferred
- Thirty days elapse since the department requested the provider to sign a new provider agreement
- The provider requests termination of the agreement
- Thirty days elapse since the department provided written notice to the provider of its intent to terminate the agreement
- The provider is convicted of a criminal offense that involves fraud in any state or federal medical assistance program
- The provider is suspended or terminated from participating in Medicare
- The provider's license or certification is suspended or revoked
- The provider fails to comply with the requirements and limits of this article
- Inactivity

Ownership Change

A participating provider who sells or transfers ownership or control of the entity, or who plans to obtain a new FEIN, must provide DSS Medical Services Provider Enrollment notice of the pending sale or transfer at least 30 days before the effective date. This can be done via email to SDMEDXGeneral@state.sd.us. In a change of ownership, the seller is responsible for maintaining and ensuring access to records generated prior to the sale. This responsibility may be transferred to the buyer through a sales contract or written agreement. The South Dakota Medicaid Provider Agreement is NOT transferable to the new owner. The new owner must apply to become a South Dakota Medicaid provider and sign a new provider agreement before claims can be submitted.

Records

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least six (6) years after the last date a claim was paid or denied. Records must not be destroyed when an audit or investigation is pending.

Providers must grant access to these records to agencies involved in Medicaid review or investigations.

Third Party Liability

Sources

Third-party liability is the payment source or obligation, other than Medicaid, for either partial or full payment of the medical cost of injury, disease, or disability. Payment sources include Medicare, private health insurance, worker's compensation, disability insurance, and automobile insurance.

Provider Pursuit

Because South Dakota Medicaid is the payer of last resort, the provider must pursue the availability of third-party payment sources.

Claim Submission to Third-Party Source

The provider must submit the claim to a third-party liability source before submitting it to Medicaid except in the following situations:

- Prenatal care for a pregnant woman
- HCBS waiver services

- Services for early and periodic screening, diagnosis, and treatment provided under ARSD § 67:16:11, except for psychiatric inpatient services, nutritional therapy, nutritional supplements, and electrolyte replacements
- A service provided to an individual if the third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the department
- The probable existence of third-party liability cannot be established at the time the claim is filed
- The claim is for nursing facility services reimbursed under the provisions of ARSD § 67:16:04
- The claim is for services provided by a school district under the provisions of ARSD § 67:16:37

A claim submitted to Medicaid must have the third-party explanation of benefits (EOB) attached, when applicable.

Payments

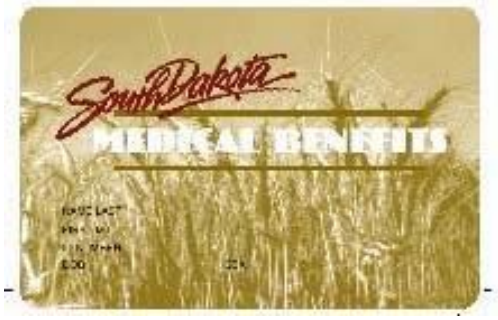
When third-party liability has been established and the amount of the third-party payment equals or exceeds the amount allowed under Medicaid, the provider must not seek payment from the recipient, relative, or any legal representative.

The provider is eligible to receive the recipient's third party allowable amount or the amount allowed under the department's payment schedule less the third-party payment, whichever is less.

When third-party liability source(s) and Medicaid have paid for the same service the provider must reimburse Medicaid. Reimbursement must be either the amount paid by the third party source(s) or the amount paid by Medicaid, whichever is less.

Recipient Eligibility

The South Dakota Medicaid Identification Card is issued by the Department of Social Services on behalf of eligible South Dakota Medicaid recipients. The magnetic stripe card has the same background as the Supplemental Nutrition Assistance Program (SNAP) EBT card. The information on the face of the card includes the recipient’s complete name (first, middle initial and last), the nine digit recipient identification number (RID#) plus a three digit generation number, and the recipient’s date of birth and sex.



NOTE: The three digit generation number is automatically added in the system to indicate the number of cards sent to an individual. This number is not part of the recipient's ID number and should not be entered on a claim.

Each card has only the name of an individual on it. There are no family cards.

Recipients must present a South Dakota Medicaid identification card to a South Dakota Medicaid provider each time before obtaining a South Dakota Medicaid covered service. Failure to present their South Dakota Medicaid identification card is cause for payment denial. Payment for non-covered services is the responsibility of the recipient, as stated in ARSD §67:16:01:07.

South Dakota Medicaid emphasizes both the recipient's responsibility to present their ID card and the provider's responsibility to see the ID card each time a recipient obtains services. It is to the provider's advantage to see the ID card to verify that the recipient is South Dakota Medicaid eligible at the time of service, as well as to identify any other program limitations and the correct listing of the recipient name on the South Dakota Medicaid file.

The Medicaid Eligibility Verification System (MEVS) offers three ways for a provider to access the state's recipient eligibility file:

- **Point of Sale Device:** Through the magnetic strip, the provider can swipe the card and have an accurate return of eligibility information in approximately 10 seconds.
- **PC Software:** The provider can key enter the RID# into PC software and in about 10 seconds have an accurate return of eligibility information.
- **Secure Web Based Site.**

All three options provide prompt response times and printable receipts, and can verify eligibility status for prior dates of service. There is a nominal fee for each verification obtained through Emdeon.

The alternative to electronic verification is to use the SD Medical Assistance telephone audio response unit (ARU) by calling 1-800-452-7691. Each call takes approximately one minute to complete. This system is limited to current eligibility verification only.

For more information about the MEVS system, contact Emdeon at 1-866-369-8805 for new customers and 1-877-469-3263 for existing customers or visit Emdeon's website at www.emdeon.com.

MEVS Eligibility Information

Through the MEVS (card swipe or PC entry) the provider receives a paper or electronic receipt ticket, immediately upon eligibility verification (approximately 10 seconds). The following is an example of the "ticket' sent to the provider.

Please note that certain South Dakota Medicaid recipients are restricted to specific limits on covered services. It is very important that you check for restrictions.

**********SD MEDICAID**********
Eligibility 10/19/2004 08:47:25
**********PAYER INFORMATION**********
Payer: SOUTH DAKOTA MEDICAL SERVICES
Payer ID: SD48MED
**********PROVIDER INFORMATION**********
Provider: Dr. Physician
Service Provider #: 9999999
**********SUBSCRIBER INFORMATION**********
Current Trace Number: 200406219999999
Assigning Entity: 9000000000
Insured or subscriber: Doe, Jane P.
Member ID: 999999999
Address: Pierre Living Center
2900 N HWY 290
PIERRE, SD 575011019
Date of Birth: 01/01/1911
Gender: Female
**********ELIGIBILITY AND BENEFIT INFORMATION**********
**********HEALTH BENEFIT PLAN COVERAGE**********
ACTIVE COVERAGE
Insurance Type: Medicaid 13
Eligibility Begin Date: 10/19/2004
ACTIVE COVERAGE
Insurance Type: Medicare Primary 13
Eligibility Date Range: 10/19/2004 – 10/19/2004

**********HEALTH BENEFIT PLAN COVERAGE**********
**********OTHER OR ADDITIONAL PAYER**********
Insurance Type: Other
Benefit Coord. Date Range: 10/19/2004-10/19/2004
Payer: BLUE CROSS/BLUE SHIELD
Address: 1601 MADISON
PO BOX 5023
SIOUX FALLS, SD 571115023
Information Contact: Telephone: (800)774-1255
TRANS REF #: 999999999

Over 150 payers now support eligibility requests. For a full list, contact fax-on-demand at 800-7602804, #536. To add new payers, call 800-215-4730.

Claim Stipulations

Paper Claims

Claims that, by policy, require attachments and reconsideration claims will be processed for payment on paper.

Electronic Claim Filing

Electronic claims must be submitted using the 837P or 837I, HIPAA-compliant X12 format.

Submission

The provider must verify an individual's eligibility before submitting a claim, either through the ID card or, in the case of long-term care, a letter from the caseworker. The provider must record the recipient identification information as required for the claim.

A provider may only submit claims for those items and services that the provider knows or should have known are covered under South Dakota Medicaid. A provider must not submit a claim for items or services that have not been completed or have not actually been provided. A provider can be reimbursed only for medically necessary covered services actually provided to South Dakota Medicaid recipients eligible on the date the service is provided.

Time Limits

The department must receive a provider's completed claim form within 6 months following the month the services were provided, as stated in ARSD § 67:16:35:04. This time limit may be waived or extended only when one or more of the following situations exist:

- The claim is an adjustment or void of a previously paid claim and is received within 3 months after the previously paid claim;
- The claim is received within 6 months after a retroactive initial eligibility determination was made as a result of an appeal;
- The claim is received within 3 months after a previously denied claim;
- The claim is received within 6 months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or
- To correct an error made by the department.

Processing

The Division of Medical Services processes claims submitted by providers for their services as follows:

- Claims and attachments are received by the Division of Medical Services and sorted by claim type and scanned.
- Each claim is assigned a unique fourteen (14) digit Reference Number. This number is used to enter, control and process the claim. An example of a reference number is 2004005-0011480. The first four digits represent the year. The next 3-digits represent the day of the year the claim was received. The next 7-digits are the sequential number order of the claims received on that day. Each line is separately adjudicated, reviewed and processed using the 14-digit reference number.
- Each claim is individually entered into the computer system and is completely detailed on the Remittance Advice.

To determine the status of a claim, providers must reconcile the information on the Remittance Advice with their files.

Utilization Review

The Federal Government requires states to verify receipt of services. Each month a sample of South Dakota Medicaid recipients are sent a survey letter requesting verification of services paid the previous month on their behalf. Such services are identified in non-technical terms, and confidential services are omitted. Although the directions are as clear as possible, providers should be prepared to assure any inquiring recipients that this letter is not a bill.

Under 42 C.F.R. part 456, South Dakota Medicaid is mandated to establish and maintain a Surveillance and Utilization Review System (SURS). The SURS unit safeguards against unnecessary or inappropriate use of South Dakota Medicaid services or excess payments, assesses the quality of those services and conducts a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers under § 42 CFR 456.23.

Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by South Dakota Medicaid.

Fraud and Abuse

The SURS Unit is responsible for the identification of possible fraud and/or abuse. The South Dakota Medicaid Fraud Control Unit (MFCU), under the Office of the Attorney General, is certified by the Federal Government with the primary purpose to detect, investigate, and prosecute any fraudulent practices or abuse against the Medicaid Program. Civil or criminal action or suspension from participation in the Medicaid program is authorized under South Dakota Codified Law (SDCL) 22-45 entitled, Unlawfully Obtaining Benefits or Payments from the Medical Assistance Program. It is the provider's responsibility to become familiar with all sections of SDCL 22-45 and ARSD § 67:16.

Discrimination Prohibited

South Dakota Medicaid, participating medical providers, and contractors may not discriminate against South Dakota Medicaid recipients on the basis of race, color, creed, religion, sex, ancestry, handicap, political belief, marital or economic status, or national origin. All enrolled South Dakota Medicaid providers must comply with this non-discrimination policy. A statement of compliance with the Civil Rights Act of 1964 shall be submitted to the Department upon request.

Medically Necessary

South Dakota Medicaid covered services are to be payable under the Medicaid Program when the service is determined medically necessary by the provider. To be medically necessary, the covered service must meet all of the following conditions under ARSD §67:16:01:06.02:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition
- It is not furnished primarily for the convenience of the recipient or the provider
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

Section I: Introduction to Health Home Service Model

1.1 Overview of the Health Home Model for Recipients with Behavioral Health and/or Chronic Medical Conditions

Health Home is a care management service model where all of the professionals involved in a recipient's care communicate with one another so that the recipient's medical, behavioral health and social service needs are addressed in a comprehensive manner. The coordination of a recipient's care is done through a dedicated care manager who oversees and coordinates access to all of the services a recipient requires in order to facilitate optimum recipient health status. It is anticipated that the provision of appropriate care management will reduce avoidable emergency department visits and inpatient stays, and improve health outcomes. With the recipient's consent, health records will be shared among providers to ensure that the recipient receives needed unduplicated services.

Health Home services will be provided through a Designated Provider either selected by the state or the recipient. A Health Home is defined as partnership of health care providers and community based organizations. Health Homes are responsible to facilitate linkages to long-term community care services and supports, social services, and family support services. South Dakota has an active Managed Care Program modeled after the Primary Care Case Management Program. Recipients in the Managed Care Program cannot be in the Health Home Program and vice versa. A recipient cannot be part of both programs at the same time. However, providers who are eligible can be both a Health Home designated provider and a primary care provider in the Managed Care Program.

The Health Home model of care differs from a Patient-Centered Medical Home (PCMH). The PCMH is a model of care provided by physician-led practices. The physician-led care team is responsible for coordinating all of the recipient's health care needs, and arranging for appropriate care with other qualified physicians and support service providers. The Federal Patient Protection and Affordable Care Act anticipates that the Health Home model of service delivery will expand on the traditional medical home model to build linkages to other community and social supports and to enhance coordination of medical and behavioral health care, with the main focus on the needs of persons with multiple chronic conditions.

1.2 Health Home Population Criteria

Health Home services are provided to a subset of the Medicaid population with complex chronic health and/or behavioral health needs whose care is often fragmented, uncoordinated and duplicative.

This population includes categorically and medically needy beneficiaries served by Medicaid and Medicare/Medicaid dually eligible beneficiaries who meet Health Home criteria. South Dakota defined our eligible population as follows.

1. Medicaid recipients with two or more chronic conditions or recipients with one chronic condition who are at risk for a second chronic condition.
   A. Chronic conditions include: Mental Health Condition, Substance Use Disorder Asthma, COPD, Diabetes, Heart Disease, Hypertension, Obesity, Musculoskeletal and Neck/Back disorders.
   B. At-risk conditions include: Pre-Diabetes, tobacco use, Cancer, Hypercholesterolemia, Depression, and use of multiple medications (6 or more classes of drugs).
2. Recipients who have a Severe Mental Illness or Emotional Disturbance.

Additional information on Health Homes for recipients with chronic conditions is contained in the Medicaid State Plan Health Home Amendment, #13-0008 which may be viewed by visiting the link below.

http://dss.sd.gov/docs/medicaid/medicalservices/3_ServicesGeneralProvisions/3.1/Attachment%203.1-H.pdf

1.3 Federal Core Health Home Services

The Health Home service delivery model is designed to provide cost-effective services that facilitate access to a multidisciplinary array of medical care, behavioral health care and community-based social services and supports for recipients with chronic medical and/or behavioral health conditions. Health Home services support the provision of coordinated, comprehensive medical and behavioral health services through care coordination and integration. The goal of these core services is to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote use of Health Information Technology (HIT), and avoid unnecessary care. Section 1945(h)(4) of the Social Security Act defines Health Home services as "comprehensive and timely high quality services" and includes six Health Home services to be provided by designated Health Home providers.

Health Home Services include:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives;
5. Referral to community and social support services if relevant; and
6. The use of HIT to link services, as feasible and appropriate.

Health Home providers are required to maintain written documentation that clearly demonstrates how the core service requirements are being met. Definitions of the six core service requirements are available at this link:
http://dss.sd.gov/docs/healthhome/pcpcoreservicesspecific.pdf

1.4 South Dakota Health Home Provider Functional Requirements

Under South Dakota's approach to Health Home implementation, a Health Home designated provider is the central point for directing patient centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up and improving patient outcomes by addressing primary medical, specialist, long term care, home health and behavioral health care needs through direct provision, or through arrangements with appropriate service providers of comprehensive integrated services. General qualifications are as follows:

- Health Home providers must be enrolled (or be eligible for enrollment) in the SD Medicaid program and agree to comply with all Medicaid program requirements, including those outlined in the Health Home Provider Standards document and the Health Home Core Services document.
- Health Home providers can either directly provide, or arrange for the provision of, Health Home services. The Health Home designated provider remains responsible for all program requirements.
- Health Home providers must have completed Electronic Health Record (EHR) implementation and use the EHR as its primary medical record solution, prior to becoming a Health Home provider.
- Health Home providers must electronically report to the State (in a manner defined by the Department of Social Services) information about how the Core Services are being met and the outcome measures.
- Health Home providers must work in concert with the South Dakota Department of Social Services, on an as needed basis, to evaluate and continually improve the South Dakota Health Home model as a means to achieve accessible, high quality care, and demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model.
- Health Home providers must comply with 42 CFR as it pertains to sharing data for patients with substance abuse disorders.
- Health Home providers must attend all required Health Home trainings.
- Health Home providers must provide the services as outlined in the Medicaid Directors letter SMDL 10-24 including
    - Provide quality driven, cost effective, culturally appropriate and person-and family center health home services;
    - Coordinate and provide access to high quality health care services informed by evidence based clinical practice guidelines;
    - Coordinate and provide access to preventive and health promotion services including prevention of mental illness and substance use disorders;

- Coordinate and provide access to mental health and substance abuse services
- Coordinate and provide access to comprehensive care management, care coordination and transitional care across settings. Transitional care includes appropriate follow-up from transfer from a pediatric to an adult system of health care
- Coordinate and provide access to chronic disease management including self-management support to individuals and their families.
- Coordinate and provide access to individual and family supports including referral to community, social support and recovery services.
- Coordinate and provide access to long-term care supports and services
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services.
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices as feasible and appropriate.
- Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes and quality of care outcomes.

Additional information regarding Federal Health Home Functional Requirements may be found at:
http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

Section II: Requirements for Health Home Participation

2.1 Health Home Application

New clinics can apply for Health Home status at any time. Additionally designated providers may attest at approved Health Homes at any time. While application can be made at any time, new Health Homes can only begin their work at the beginning of each quarter as defined below. This gives new Health Homes sufficient time to engage their recipients and provide a core service before the quarter ends.

New Health Home Start Dates are as follows.

- January 1
- April 1
- July 1
- October 1

A list of the designated providers can be found at:
http://apps.sd.gov/SW96PC01MED/Default.aspx?Code=H

Designated providers for Health Homes include providers licensed by the State of South Dakota who practice as a primary care physician, (e.g., family practice, internal medicine, pediatrician or OB/GYN), physician's assistants, an advanced practice nurse practitioner working in a Federally Qualified Health Center, Rural Health Clinic, Indian Health Service Unit (IHS) or clinic group practice or a mental health professional working in a Community Mental Health Center. Each designated provider will sign an attestation that they meet the provider standards.

A Health Home may include multiple sites identified as a single organization that shares policies, procedures, and electronic systems.

The designated provider leads a team of health care professionals and support staff that may include a primary care physician, physician assistant, advance practice nurse, behavioral health provider, a health coach/care coordinator/care, chiropractor, pharmacist, support staff, and other services as appropriate and available.

2.2 Provider Enrollment Instructions for Health Homes

Once a Health Home application has been reviewed and approved by the State, the Health Home provider will receive a letter of notification from the Department of Social Services indicating their status as a designated Health Home. Any contingencies to the designation will be identified and described in this letter. The contingently designated Health Home is required to respond within an appropriate timeframe with an acceptable plan that addresses any

contingencies to the satisfaction of the State in order to become officially designated.

2.3 Designated Health Home Disenrollment

Unless it is a closure situation, a Health Home may only discontinue providing Health Homes Services at the end of a quarter with a minimum of three (3) months' notice to the Department of Social Services (DSS). Health Home services may not be discontinued without having an approved closure/services cessation plan, which includes proper procedures for clinically appropriate recipient transition.

2.4 Health Home Provider Eligibility and Enrollment of the SD Medicaid Program

Health Homes are approved on a clinic basis. Within those clinics there would be designated providers. To become a Health Home a clinic or provider must do the following

- Make application for the Health Home Program using the Application found at http://dss.sd.gov/healthhome/application.aspx
- Use the instructions on http://dss.sd.gov/healthhome/application.aspx to complete and submit the application and required attestations.
- Work with the Division of Medical Services to schedule onsite training for the Health Home Program.

2.5 Health Home Changes to Originally Approved Health Home Application

Health Homes are responsible to adhere to the Health Home provider qualification and standards, functional requirements, and guidelines as outlined by the Centers for Medicare and Medicaid Services (CMS), in the State Medicaid Director Letter (SMDL) #10-024, Health Home for Enrollees with Chronic Conditions. DSS should be notified immediately if the following:

- Provider additions or deletions
- Transitional Care Contact changes
- Updates or changes to where reports such as the Quarterly Core Service template or the Caseload Reports should be sent.

Notifications can be made to

Division of Medical Services
Health Homes Program
700 Governors Drive
Pierre, SD 57501
605.773.3495

Section III: Claims Submission and Billing for Health Home Services

3.1 General Requirements for Health Home Claim Submission

Medical Services for enrolled Health Home recipients are reimbursed on a fee-for-service (FFS) basis. Claims for covered services provided by another designated provider within the Health Home do not require referral information on the claim. Covered Health Home services provided by a provider referred by the Health Home Provider (HHP) must have the HHP's NPI number included on the claim according to Chapter XVII Block 17a/b. Exempt emergency care, urgent care, IHS-referred contract care, and dental-related care must be billed according to Chapter XVII Block 10d, and Block 24c. Exempt family planning services should be billed with an "F" in Block 24H according to Chapter XVII Block 24. Electronic claims cannot use box 10d for Managed Care exemptions. (See the HIPAA companion guide for the emergency indicator location for electronic claims).

3.2 Per Member per Month Health Home Payment

Providers will be paid a Per Member Per Month (PMPM) Payment on a quarterly basis. The PMPM will be calculated based on the number of months the recipient was in the Health Home dueing the quarter, the tier of the recipient, and reported provision of a core service.

Each recipient in Health Homes must receive one (1) core service per quarter. If a core service is not provided, the PMPM payment cannot be claimed.

Health Homes are required to complete the quarterly core service report online through Launchpad at the end of each quarter. Dates to report will be listed below. Providers will have until the end of the following month to complete their report.

- January – March quarter: March 31 – April 30
- April – June quarter: June 30 – July 31
- July – September quarter: September 30 – October 31
- October – December quarter: December 31 – January 31

The PMPM payment for Health Home Services will be made during the first week after the due date of each quarterly core service report

3.3 Disenrollment of Health Home Recipients by the Health Home

A Health Home recipient can be disenrolled by the Health Home without the recipients consent for the following reasons.

- Inability of the Health home team to contact them.

- Behavioral issues.

Policies on the steps required for each of these scenarios can be found at http://dss.sd.gov/healthhome/training.aspx.

Once the Health Home has followed the policies in these two areas, the Health Home may disenroll the recipient by submitting the Decline to Participate Form found at http://dss.sd.gov/healthhome/forms.aspx.

Section IV: Rate Calculation and Methodology

4.1 Health Home Tiers

Both the Community Mental Health Center (CMHC) and the Primary Care Provider (PCP) Health Homes have a unique PMPM payment for each tier. Each Health Home type is able to serve the recipients within each of the different tiers. Recipients are placed in the type of Health Home based on a continuity of care algorithm. Recipients are assigned a tier based on the Chronic Illness and Disability Payment System. Additional Information on Tier Payments can be found at http://dss.sd.gov/healthhome/pmpmpayments.aspx

4.2 Health Home Performance Measures

Health Home Performance Measures are a critical factor of determining the success of Health Homes. Performance Measures are made up of Clinical Outcome Measures, Process Measures, and Utilization Measures. Performance Measures and Data File Layouts can be found at the following site: http://dss.sd.gov/healthhome/outcomemeasures.aspx.

Performance Measures are reported to DSS on a biannual basis using the following schedule.

Biannual Outcomes Measures Data

Submission Deadline	Data to be Submitted
February 28	July– December
August 31	January – June

Method of Reporting for Biannual Outcome Measures Data

1. Each Health Home will export the Outcomes Measure data in a file format outlined at http://dss.sd.gov/healthhome/outcomemeasures.aspx.
2. DSS will pull claims data to complete the remaining Outcomes Measures

Section V: Recipient Assignment, Enrollment and Disenrollment

5.1 Medicaid Eligibility Determination for Health Home Recipients

It is important to determine Medicaid eligibility prior to providing Health Home services as recipients entering Health Homes must be enrolled in Medicaid, and Medicaid is date specific. A recipient's Medicaid eligibility may change frequently and it is incumbent on the provider to assure that they are providing services to a Medicaid recipient prior to rendering services. If the provider does not verify eligibility and the extent of coverage of each recipient each time services are requested, then the provider may be at risk for non-reimbursement for services provided, as the State cannot compensate a provider for a service rendered to recipient who is not an eligible for Medicaid. In determining the recipient's Medicaid eligibility, the provider is responsible to review the type of Medicaid coverage authorized, as well as any restrictions that may exist.

It is also important to ensure that the recipient is in the provider's Health Home prior to providing services. If they are not, the provider should work to assist the recipient in connecting with their Health Home or securing a referral from the recipient's Health Home.

If a recipient is not eligible for Medicaid or Medicaid coverage has lapsed, the referring entity should work with the Department of Social Services local office to apply for or reactivate Medicaid coverage. Persons not eligible for Medicaid should be provided with assistance in finding appropriate health care options.

Recipient Medicaid eligibility information, including covered services, is identified in the Medicaid eligibility verification process. For more information, consult the information in the Professional Services Billing Manual regarding Medicaid Eligibility Verification System (MEVS) Manual, online at:
http://dss.sd.gov/sdmedx/includes/providers/billingmanuals/docs/Professional2.6.14.pdf

5.2 Recipient Eligibility and Assignment

Each month recipients are determined eligible based on claims data for the previous 15 months. Eligible recipients are then tiered using the Chronic Illness and Disability Payment System (CDPS). The claims data is also used to determine if recipients in Tiers 2-4 have continuity of care with an enrolled Health Home provider. If they do, they are automatically assigned to that provider at the beginning of the first month following a 30 day period. During that time, recipients can opt out of the program if they do not wish to participate or they can change Health Home providers if they wish to have a different provider.

Those who do not have continuity of care are sent a letter asking them to pick a provider. They can choose to opt out of the program. If they do not pick a provider or opt out of the program,

DSS makes contact with them to talk about the program and help them make a decision about participation.

Each month Health Homes are provided a Caseload list which includes the recipients that should be served by the Health Home. Providers should compare their lists to the previous month's list to make sure recipients have not opted-out of the program or lost eligibility.

5.3 Claims Data

Each month Health Homes receive a file of claims data on each Health Home recipient in their Health Home at the time the claims report is run. This information is loaded to a secure FTP site and can be downloaded by the Health Homes in two different formats. Description of the format the format can be found on
http://dss.sd.gov/docs/healthhome/ClaimsDataExtractforHealthHomeProviders.pdf

5.4 Recipient Opt–Out

Health Home recipients have the right to opt-out of the Health Home program. The Decline to Participate Form can be found on http://dss.sd.gov/healthhome/forms.aspx.
Health Homes can complete this form with verbal indication from the recipient that they wish to remove themselves from the program. Verbal indication should be documented in the Electronic Health Record. Forms should be faxed to (605) 773-5246.

5.5 Recipient Changing Health Homes

Health Home recipients can choose to switch their Health Home provider. The Selection and Change Form can be found on http://dss.sd.gov/healthhome/forms.aspx. All changes will go into effect on the first day of the following month. If a special request is made by the recipient or the recipient's caseworker, to change the Health Home provider prior to the established cutoff date, the most recent occurrence can be removed and the new provider can be added on the first day of the following month. If the request is received after the established cutoff date, the occurrence must remain and should be ended at the end of the month. If a provider, recipient or caseworker can provide written documentation that there is a DSS error, or a core service has not been provided, occurrences can be removed when payment has already been made. If payment has been made, DSS will work with the provider to recoup necessary payments. Documentation should be kept as appropriate. Forms should be faxed to (605) 773-5246.

5.6 Manual Tiering of Recipients

Health Homes can recommend that recipients become part of a Health Home by completing the Manual Tiering Document that can be found on http://dss.sd.gov/healthhome/forms.aspx. This allows the Department of Social Services to determine eligibility and tier in a consistent manner.

Section VI: Recipient Referral Process

6.1 Transition and Access to Other Medicaid Services

Health Homes are responsible for assuring that their recipients receive all medically necessary care, including primary, specialty and behavioral health care. Referrals can be done using the referral templates that can be found on http://dss.sd.gov/healthhome/forms.aspx, or they can also be done electronically or telephonically. All referrals must be documented in the recipient's electronic health record. Services that are provided without a referral will be the recipient's responsibility.

6.2 Hours of Service

Health Homes must provide same day appointments and must also provide 24 hour/7 day a week access by telephone which will immediately page an on call medical professional to handle medical situations during non-office hours. A plan for after-hour care must be communicated with the recipient and documented in the recipient's electronic health record. If the health home is affiliated with a calling network to serve as the after-hours contact, this may be utilized for general purpose calls only. Any referrals given to recipients through these calling networks (e.g. referring recipients to seek medical attention in the emergency room) must be prior approved by the recipient's health home designated provider or designated covering provider.

Section VII: Health Information Technology

7.1 Electronic Health Records

Health Homes are required to us an Electronic Health Record to store information such as Care Plans, Core Services and other Health Home related tasks.

Section VIII: Health Home Record Keeping Requirements

8.1 Quality Assurance Reviews

On occasion, DSS will conduct quality assurance by requesting portions of a recipient's EHR. The quality assurance reviews will help ensure that appropriate Health Homes are meeting Health Home Requirements. Reviews may include, but are not limited to the following

- Core Services are being provided as indicated
- Care Plans are being developed and followed as appropriate
- Appropriate Notifications and contacts are being done for the recipient
- Mental Health and Substance Abuse Screenings are being done for each recipient.